STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055992	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER: West Covina Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 850 S. Sunkist Ave. West Covina, CA 91790	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37198 Based on observation, interview, and record review, the facility failed to provide the necessary care and services as indicated in the facility's policies and procedures (P&P) titled, Change in a Resident's Condition or Status and Goals and Objectives, Care Plans for one of three sampled residents (Resident 1) by failing to: 1. Ensure assigned Licensed Vocational Nurses (LVNs) assessed, monitored, and documented Resident 1's left cheek discoloration as a change of condition (COC - clinical change from a resident's baseline in physical, cognitive, behavioral, or functional status) in Resident 1's clinical record. 2. Ensure assigned LVNs developed a care plan (CP - a formal process that outlines the goals, objectives, and evaluation of the nursing care provided for a patient) regarding Resident 1's left cheek discoloration. 3. Ensure assigned LVNs notified Resident 1's physician regarding Resident 1's left cheek discoloration. These deficient practices had the potential for a delay of care and services to Resident 1. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated, the facility admitted Resident 1 to the facility on [DATE], with diagnoses of atherosclerotic heart disease of native coronary artery (plaque buildup in the wall of the arteries that supply blood to the heart) without angina pectoris (chest pain or discomfort), heart failure (when the heart cannot pump enough blood) and dementia (the loss of the ability to think, remember, and reason to levels that affect daily life and activities). During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/6/2024, the MDS indicated, Resident 1 was understood by others and had the ability to understand others. The MDS indicated, Resident 1 was dependent (helper did all the effort) with toileting hygiene, showering/bathing self, lower body dressing, and putting on/taking off footwear. During an observation on 7/3/2024 at 11:32 am, in the facility's dining/activity room, Resident 1 was observed with purple discoloration on Resident 1's left cheek. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's clinical record, the clinical record indicated no documentation of a COC report and a CP completed by the facility regarding Resident 1's left cheek discoloration. During an interview on 7/3/2024 at 2:31 pm with Certified Nursing Assistant (CNA) 1, CNA 1 stated she saw a discoloration on Resident 1's left cheek on 7/2/2024. CNA 1 stated she informed LVN 1 about the discoloration on 7/2/2024. CNA 1 stated LVN 1 informed her that LVN 1 would complete a report about Resident 1's discoloration. During an interview on 7/3/2024 at 2:46 pm with LVN 1, LVN 1 stated on 7/2/2024, CNA 1 reported to her that Resident 1 had slight redness on the cheek. LVN 1 stated LVN 1 did not remember which side. LVN 1 stated she informed oncoming staff to keep an eye on it. LVN 1 stated Resident 1 had a habit of touching Resident 1's face and LVN 1 had observed it happen at least three to four times. LVN 1 stated there was no COC report done regarding Resident 1's cheek discoloration. LVN 1 stated Resident 1's face looked like Resident 1 had been playing with it. LVN 1 stated the facility needed to develop a CP for Resident 1's behavior of touching the face. During an interview on 7/3/2024 at 2:58 pm with the Assistant Director of Nursing (ADON), the ADON stated a COC should be reported to the physician and be completed as soon as possible. The ADON stated the failure of not reporting and completing the COC would result in Resident 1's condition not being monitored. During an interview on 7/3/2024 at 3:24 pm with the Director of Nursing (DON), the DON stated Resident 1's skin discoloration on the cheek was noted on 7/2/2024 and the COC report should have been done on that day. The DON stated the importance of completing the COC report was so that staff could monitor if Resident 1's skin discoloration was going to get worse. The DON stated a CP needed to be developed at the time a behavior was first noted. The DON stated the facility needed to develop a CP for Resident 1's behavior of rubbing the face. The DON stated with a CP, the facility staff could follow up on the resident's behavior, check the interventions, see what the staff did, and refer to the CP if something went wrong. During a review of the facility's P&P titled, Change in a Resident's Condition or Status, revised in February 2021, the P&P indicated, the facility promptly notified the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). The P&P indicated, the nurse notified the resident's attending physician or physician on call when there had been a discovery of injuries of an unknown source. The P&P indicated, prior to notifying the physician or healthcare provider, the nurse made detailed observations and gathered relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR (Situation-Background-Assessment-Recommendation) Communication Form. During a review of the facility's undated P&P titled, Goals and Objectives, Care Plans, the P&P indicated, care plans incorporated goals and objectives that led to the resident's highest obtainable level of independence. The P&P indicated, care plan goals and objectives were defined as the desired outcome for a specific resident problem. The P&P indicated, care plan goals and objectives were derived from information contained in the resident's comprehensive assessment and were resident oriented, behaviorally stated measurable, and contained timetables to meet the resident's needs in accordance with the comprehensive assessment.